NON-FORMULARY DRUG REQUEST

FROM: *(PROVIDER'S NAME, PH# AND LOCATION)* **DATE**

PATIENT'S NAME AND SS#: **WEIGHT** **AGE** **PREGNANCY / LACTATION**

DIAGNOSIS:

REQUESTED MEDICATION **STRENGTH** **SIG**

DURATION OF THERAPY **QUANTITY** **REFILLS**

FORMULARY ITEMS OF SAME INDICATION PREVIOUSLY TRIED AND FAILED: **DOSE** **DURATION**

JUSTIFICATION FOR ORDERING OFF FORMULARY

___YES ___NO **WAS PATIENT COUNSELED ON USE OF TRICARE MAIL ORDER PHARMACY *(TMOP)***

Non-Formulary Drug Request Approval Guidelines:

** ONE OR MORE OF THE FOLLOWING MUST APPLY TO OBTAIN APPROVAL**

-Formulary items of the same therapeutic drug class or those that carry the same indication must have been tried and failed for an ample duration of therapy at the maximum therapeutic dose.
-A documented allergic response or intolerance to the formulary medication must exist.
-Patient has an existing diagnosis or condition in which the formulary medication is contraindicated.
-Patient is currently taking additional medication that is contraindicated with formulary medication.

***** PATIENTS SHOULD BE ENCOURAGED BY PROVIDER TO USE TMOP AS TMOP IS THE PREFERRED ROUTE OF OBTAINING NON-FORMULARY MEDICATIONS***